

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, March 19, 2004
9:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
AUTRY O.V. DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Hospice care in Medicare: Recent trends and a review of the issues - Sarah Thomas, Cristina Boccuti

MR. HACKBARTH: And now we need to move on to our last item, an update on hospice care.

MS. THOMAS: I'll try to go relatively quickly since this is the last presentation.

In brief, just to remind everybody, hospice is for beneficiaries who elect to forego curative care and whose doctors certify that they have six months to live if the disease follows the expected course. Once a beneficiary elects hospice, the hospice can cover palliative care, that is which focuses on managing the symptoms of disease but not curing it. The benefit includes nurse visits, prescription drugs, respite care for families, inpatient care as needed and bereavement counseling.

Palliative care is not the focus of today's presentation, but I did include at your seats an article that was recent in the Wall Street Journal about palliative care units in hospitals which, if you're interested, we could certainly consider in future work.

The Commission is on record with two sets of recommendations on payment for hospices and on quantity from reports in 1999 and 2002. We haven't looked at hospice for a couple of years. There's been dramatic growth in the use of the benefit which prompts reviewing those recommendations again and some of the issues that are raised.

Hospice is something of a black box, so with all of the growth we want to take another look at the payment system and the status of quality measurement for hospices.

First, I'm going to review some trends, bringing our data up through 2002, and then we'll review your recommendations and some of the recommendations that have been made by others for improving payment and other policy.

Overall growth in the use of the hospice benefit has been dramatic. For beneficiaries who died while they were in the fee-for-service program, it's grown from about 16 percent in 1998 to 25 percent in 2002. This can be thought of as a success story in that many have been concerned that hospice with important benefits targeted towards improving care the dying has been underused.

This graph shows the increase in the use by age group. You can see that there's been a large shift in the age structure of users over this time period. In 1998, the group of decedents with the highest rate of hospice use was beneficiaries between 65 and 74. There is much higher use among all groups of aged beneficiaries now, including the very oldest.

This pattern of growth among beneficiaries at all

age groups is consistent with reports that MedPAC and others have documented of growth in the use of the benefit by beneficiaries with diagnoses other than cancer and beneficiaries who live in nursing homes.

Another issue I wanted to take a look at, following up on some of the questions that Jack raised at our September meeting was the use of the benefit by race. Both researchers and providers have noted historically lower use of hospice among African-American beneficiaries. Indeed, while decedents of all races are in hospice more over this time period, gaps in the use continue to persist, most notably for Asian beneficiaries. Researchers attribute differences to different attitudes towards among different ethnic groups which reflect complex belief, religious, cultural and education issues.

DR. NELSON: Sarah, on that previous slide, to the degree that Asians represent a smaller percentage of the population, would they actually have a higher percentage of Asians using it?

MS. THOMAS: This is among people who died, what percent of them died while in hospice. So yes, the numbers would be smaller but the relatives should be the same.

DR. ROWE: The number of Asians who died who were in hospice has gone from 10 percent to 14 percent but it's still a lower percentage.

DR. NELSON: Got you, thank you.

MS. THOMAS: As others have found in earlier work, we find persistently higher use of hospice among decedents who were enrolled in managed care plans. In 2002 more than a third of decedents in managed care plans used hospice compared with a quarter of beneficiaries in fee-for-service.

Some have speculated this may be because people in plans or their physicians are more accustomed to receiving a variety of types of services from a single source so there might be a proclivity to use hospice among those folks.

It's also consistent with the incentives of the payment system which allows beneficiaries to stay enrolled in their plan when they receive hospice care. When the plan and enrollee elects hospice, Medicare makes a partial capitation payment to the plan to cover non-Medicare benefits that the plan was offering and also pays for hospice care and any non-hospice Part A and Part B services on a fee-for-service basis.

Although one might expect a higher use of the benefit among decedents in managed care to signal a better referral system, and thus earlier referrals to hospice, we actually don't find earlier referrals to hospice. In fact, the referrals are very similar if not slightly later if you look at the distribution of days of length of stay.

On this table we show that the average length of stay has grown since 1999, however the median length of stay declined and then has remained relatively flat. As you can

see, more than 25 percent of beneficiaries stayed less than one week in hospice and the growth in the mean is really being driven by longer stays at the high end. You can see a particularly large jump at the 90th percentile between 2001 and 2002.

Length of stay is an important issue in hospice for a couple of reasons. One is that short stays mean that beneficiaries and their families have relatively little time to prepare for death while using the benefit. Of course, an explanation for the large number of short stays is that acceptance of death and the decision to elect hospice may be relatively concurrent with death.

It's also true that prognosis is very difficult, as many have written about in research. It's very difficult to predict when someone will die.

Some researchers have found that hospices report higher costs associated with the first and last day of a hospice stay, for instance the intake procedure on the first day can be resource intensive. So if you have a longer length of stay, then you could spread those costs over more days of care.

However, on the other hand, people with short stays may be less likely to be the ones who require intensive and expensive palliative treatments, including drugs and radiation kinds of therapies that we've heard from hospices that are expensive, but are palliative in nature.

Not surprisingly, given the growth of the use of the benefit, Medicare spending has risen from \$3.5 billion in 2001, to almost \$6 billion in 2003. This is 30 percent growth in spending for each of the last two years.

In the next few slides I'm going to go over some of the issues that we highlight in the chapter. The first and fourth bullets are areas where the Commission has made recommendations in the past. In 2002 your recommendations on payment were in our report on access to hospice and in the quality improvement it was in 1999, the June report.

Just as a quick review of the payment method for hospice, hospices are paid per diem, four possible rates. The vast majority of care is for routine daily care where the daily rate is about \$120 a day. The alternative payment rates are continuous care, which is pretty much someone is there throughout the day; inpatient care which can take place in a hospital or a SNF or if the hospice has its own unit it could be in hospice unit; and inpatient respite which is provided to provide respite for family members who care for the patient. From this payment hospices provide a large number of palliative services which I mentioned at the beginning.

A policy that I wanted to highlight for you is that for the managed care enrollees who elect hospice. This may have something of a dampening effect on plans' incentives to develop innovative coordinated approaches to

end-of-life care, as I'll get into in a minute.

Another point I wanted to mentioned briefly, in one section of your mailing materials I summarized for you a recent article that was published in the Annals of Internal Medicine by a group of researchers from Rand. In September, Jack had asked about the evidence on savings of hospice to Medicare. This study that just came out last month shed some light on that question.

It's more rigorous than some of the other studies that have been done recently in that it controls for beneficiaries' propensity to choose hospice and their age and their diagnosis. And the finding, the bottom line is they found that for people who have a diagnosis of cancer there are program savings to Medicare from the election of hospice but the reverse is true for beneficiaries with other diagnoses where the hospice program increases spending.

Last, I'm going to go over your recommendations on quality and bring you up to speed on where you are in terms of measurement. In 2002, you recommended that the Secretary evaluate hospice payment rates to ensure they are consistent with the costs of providing appropriate care, Research differences in the and in resource needs of hospice patients, and study case-mix adjustment and an outlier policy. I just wanted to point out hospices, like other providers, can choose which patients they decide to take so there are likely to be differences in the resource costs they experience as a result.

Other researchers have suggested a number of other payment refinements that could be made to hospice payment rates including a higher per diem for the first and last days of the hospice stay.

Another idea has been to look at the differences in the cost for hospice travel cost to determine whether costs are higher if there's more travel involved. For example, to rural locations.

Related to the outlier policy, the hospice industry folks that we've talked with have told us that drugs and other palliative therapies are important drivers of cost their experiencing. So it would be interesting to take a look at this.

Another issue that some people have put on the table is whether costs might vary by whether beneficiaries live at home or in a nursing home. It may be possible that a hospice visiting a nursing home who has several patients there, there may be some economies of scale associated with seeing five patients in the same place rather than having to go to five different locations.

In April, Cristina and I will bring you some data on the costs and variation in cost for hospices, but to assess all these payment issues probably we will need to see some more data on the services that are provided to different patients.

Options for thinking about more data include adding field claims, for example, that might show numbers of visits that took place, perhaps beefing up detail in the cost report or collecting data through a sample as in a demonstration. Of course, improving any payment method and collecting data to do so would have to be balanced with the burden on providers and CMS of data collection, so it should be considered carefully.

Coming to the policy for managed care enrollees, you may want to discuss this issue which is sort of the advantages and disadvantages of the current policy for managed care enrollees. If a plan enrollee elects hospice they receive all -- just review one more time, they receive all the Medicare benefits on a fee-for-service basis but continue to stay in the plan and Medicare pays for the non-Medicare benefits through a reduced capitation rate.

Some disadvantages of that policy are that it deters some plans from thinking about end-of-life care as a more continuous benefit and integrating it with the other Medicare Part A and Part B benefits that they are responsible for providing. However, I should be fair in saying that we have heard about examples from some plans, notably Kaiser, Sutter in California, and some of the BlueCross BlueShield plans that have developed interesting and innovative palliative care programs. So there are some lessons, I think, that we would be able to learn from these for perhaps our chronic care management which has got to be tied into end-of-life care.

Some other thoughts about the policy are its administratively complex. CMS has to figure out for each plan what the partial capitation rate must be based on the difference between the payment and the benefits the plan offers. It does raise Medicare costs, as demonstrated in a study that was done several years ago by some folks at CMS. And it does single out hospice from other Medicare benefits.

It also explicitly pays for non-Medicare benefits for a group of beneficiaries, which is unusual.

On the other hand, you do see that plans and hospices have the incentive to increase use of the hospice care, which is an important consideration as well.

This brings us to quality. As I said in the 1999 June report on improving care at the end-of-life, you recommended that the Secretary make end-of-life care a national quality of care improvement priority and sponsor projects to develop and test measures of the quality of end-of-life care for Medicare beneficiaries.

Private foundations and the hospice industry have made progress in developing measure sets for capturing quality among many domains of hospice and palliative care more broadly. The hospice conditions of participation don't right now include any requirements for measurement or improvement based on measurement. Three organizations do

accredit hospices and they do make the requirement that quality be measured and improved. And most hospices are accredited by these organizations. So including that in the conditions of participation probably is realistic. The National Association of Hospice and Palliative Care has been at the forefront of a number of voluntary quality improvement and reporting initiatives.

Like other beneficiaries, those using hospice are vulnerable and measures are being developed and tested and probably many could be reported if data could be collected. There is a fair amount of agreement over the important domains of care for hospice quality, which include issues of whether the patient was comfortable and safe and whether his or her choices of place of death were followed.

A path to moving in this direction of measuring quality could be the one that is being used for hospitals where you start with quality measurement for internal improvement in the conditions of participation and then perhaps with support by the QIOs, and then move to a public reporting as data collection and other issues are worked out.

Another path would be the example of home health where there's a research contract that's let to a researcher who developed the measure set and measures their validity. Again, as with refinement of payment, any data collection on quality should be balanced with the burden on CMS and the hospices themselves.

So now I'm going to turn to Cristina, who's going to talk about the work we're going to bring to you in April.

DR. ROWE: I'm sorry, can I interrupt? I have to leave and I wanted to make one comment about this. And I apologize for interrupting.

This is excellent. Thank you very much. It's a very important population.

I think one of the concerns that we should have in Medicare has to do with the requirements for participation on the part of the beneficiary. The beneficiary has to basically give up all attempts for curative care. And I think that in many patients that's very difficult.

The care providers find themselves in a situation where they really want to say to the patient, and the patient wants to hear, we haven't given up on you but we're at the point where you should start thinking about how you're going to handle things if things continue along the way we think, but we're not giving up all hope. But to get them to sign that they're giving up all hope, you know, sort of the Medicare hospice program has got a sign over it abandon hope all ye who enter here.

I think that that is a significant issue. I think it influences length of stay because it keeps people out of the program until a point in their term when it's not advantageous.

Hospices, while we like short lengths of stay in general in health care facilities and Medicare, in hospice we want long lengths of stay. The longer somebody's in a hospice the more benefit there is. And there's very little benefit to a very short, a six-day length of stay in a hospice is basically the last rites. It's not taking advantage of the hospice and what it has to offer the family as well as the patient.

And I apologize again for interrupting. I'm sorry that I have to leave but I did want to make that point.

I may be alone in this, but I think that it would be helpful to speak with some experts, which I'm not, in the care at the end-of-life and get some views from CMS and others about how important this requirement is and whether there's any room anywhere to loosen it up.

Clearly the benefit is being much more used. It's not like nobody's taking advantage of it. But the length of stay data concern me and I think that that's one of the issues there. It may not be that we're going to increase the number of people that use it but they would use it earlier and to greater benefit.

Again, I apologize for the interruption.

MS. THOMAS: Just a quick clarification, the requirement that they must decide to forego curative care is in the law.

DR. ROWE: I know.

MS. THOMAS: So that would have to change.

DR. ROWE: [off microphone.] I'm not suggesting it's your requirement, Sarah.

DR. REISCHAUER: But what are you suggesting, that you say well, I'm going to forego some curative care? Or I can have a little of both?

DR. ROWE: I suggest you do what Aetna does. The health plans, and I think to my knowledge all of the health plans have a much more flexible definition. If the physician believes that it's appropriate at this time for the patient to get hospice care, they can hospice care. And you don't have to sign something saying that you will not consider any additional ongoing curative care. It's just forcing the patient to do that, we find it counterproductive. So we don't have that requirement.

DR. MILLER: One thing that we could do is we can look at some of the plans that you were identifying and ask how they control this issue.

MS. DePARLE: I think that's true and it's a concern. I mean, obviously when this benefit was put in I'm sure that part of the cost of it was estimated by CBO depending on whether people were -- it would have been much more expensive if they had assumed that people would continue to get everything.

I think Mark's idea and your idea of looking at what other plans of doing. And do you find that once a

physician and a patient elect hospice that, in fact, the other spending is restrained? That they are more going that route? It would be interesting to look at.

DR. ROWE: [off microphone.] Unfortunately, I come armed with an opinion but not with any data which is not unusual. But we'd be happy to share our experience. I think it's a more user-friendly approach.

MS. DePARLE: I think we agree on that, yes.

MS. RAPHAEL: I think there are different dimensions here, because I think we're confusing -- one thing is foregoing curative treatment, which is very difficult to do. And then we get into whether there's some sort of aggressive pain management, which sort of falls over the line.

A second is the six-month prognosis, which is also difficult to do.

A third is whether it's upon the physician's recommendation or whether the patient has to really be engaged in making this decision.

So I think there are a number of different requirements here that we need to separate out as we think about this.

DR. REISCHAUER: I wouldn't disagree that Jack's approach would be a more humane and better approach, but we've already been told that, according to the Rand study, this is a benefit that now is costing more than if it didn't exist.

DR. ROWE: [off microphone.] Only for non-cancer patients.

DR. REISCHAUER: But on average is the thing.

DR. ROWE: [off microphone.] But cancer patients are the majority of patients. And so for the majority of patients --

MS. THOMAS: The aggregate is a cost when you consider all the cancer and non-cancer patients together.

MS. DePARLE: How much of a cost?

DR. ROWE: [off microphone.] Who are we going to take better care of if not these?

MS. THOMAS: I think it's 4 percent in the aggregate. Depending on the diagnosis of the patient you look at it can be anywhere from 11 to 30 percent higher for the non-cancer group.

DR. REISCHAUER: As I said, I'm not opposed to a better benefit but we should view it as that and weigh it against other ways to increase the quality of the benefit.

DR. ROWE: [off microphone.] Let's look if the criteria for the benefit are, in fact, counterproductive. I'm not trying to increase the cost. Let's just see what we buy for that extra cost, if anything.

DR. NEWHOUSE: But the fact that the private market supports it suggests that --

DR. REISCHAUER: But the private market supports

it because there are very few people who are affected in Jack's plan compared to Medicare. I mean, Medicare everybody is going to be affected.

DR. ROWE: [off microphone.] I think that's right. As I leave, I'd like to agree with something that Bob says.

DR. REISCHAUER: It's taken five years.

DR. ROWE: [off microphone.] Because the average age of our beneficiaries in the commercial plans is in the 30s or early 40s and so that's certainly the case, yes.

MS. BOCCUTI: Let me just go over the little bit of what we plan to bring you in April, but I think that discussion is very much about the genesis of the benefit, too, and ways that maybe the Commission wants look at it.

We're also, in April, going to be bringing to you our analyses from cost reports. And as you may know, hospice cost reports are a relatively new endeavor. And so we're just getting to the point where there's enough data there to analyze. So potentially our analysis may shed some light in areas where you might want to look into regarding hospice payment refinement.

We plan to examine components of hospice costs such as nursing costs, drug costs, transportation costs and ways that they vary by facility, characteristics, size type, et cetera.

And we also will be discussing the limitations of the cost reports. We'll bring to you some discussion on changes in the composition of the industry over time. That is growth in for-profit, not-for-profit, freestanding, hospital-based, home health based, and nursing home-based hospices.

And I leave you saying if there are any particular cost reporting issues that you want us to focus on for the April presentation, please let us know.

MS. RAPHAEL: I just was at an investor conferences in which I found out that investors who look at home health at all are most interested now in hospice, which I wasn't fully aware of. Because there are a number of public companies now in hospice who are doing very well.

And so I'm seeing an industry where you have one group now with high earnings and you have this other group that somehow can't even break even. And I'd like to better understand the industry and what's accounting for the distinction.

MS. BOCCUTI: I hope that we will be able to provide some insights into that to the best of our ability and see what we can come up with in April, if we can look at different types of hospices and those issues.

DR. REISCHAUER: Sarah, I think you said that there had been a rather rapid growth in SNF related participation in nursing home. I'm not arguing that this is wrong or bad or anything, but is this a situation in which

we have individuals in nursing homes being paid for by Medicaid and towards the end of their lives by switching them into a related inpatient hospice facility the average payment can be both shifted to the federal government from the state and increased? That might explain some of it. And it's not irrational, it's not necessarily wrong.

MR. HACKBARTH: Although I think that's the sort of thing that the earlier requirements we were discussing were designed to prevent. It was to put barriers to the growth of this, of just that sort.

MS. THOMAS: We have talked to the folks from the hospice associations about this. CMS and the associations have been very careful to try to let hospices know that even if people living in nursing homes are sort of entitled to some of the same services through nursing homes, that they are to provide the same sort of care, the same kinds of care plans to beneficiaries regardless of whether they're in the nursing home or in their own home.

Also, we're told that states are aware of some of the overlap in the benefit and have sort of scaled back what they're providing on their side for beneficiaries in hospice, not providing the same degree of drug coverage, for example.

DR. REISCHAUER: On that score, do we think the Medicare drug benefit is going to affect the attractiveness of this?

MS. THOMAS: I think that's a very interesting question. I think that there's some issues around coordination of -- making sure that the drug plans know that the person has elected hospice, obviously, and is receiving palliative drugs. But they still should be able to get their non-palliative drugs. And sometimes it might be hard to tell the difference by classes. I think there will be some interesting issues there.

MS. BOCCUTI: We've been talking about this a little bit in the policy question of to what extent the patients see this as an opportunity -- we don't know. Finding out if they're looking for the hospice benefit to help them with some pain medication issues, in addition to the bereavement and the other kinds of counseling that are part of the hospice benefit. That's the added bit that the Medicare benefit provides.

But also the Commission might want to look into ways to refine payment based on the new Medicare hospice benefit. So I think there might be an interplay -- what did I say? Oh, the drug benefit. Thank you

So it may be an issue that we want look into if there is any overlap there.

MR. HACKBARTH: Okay. Thank you.